PROGRESS

VOLUME III NUMBER 4 MARCH, 1962

IN THIS ISSUE

AWARENESS · KNOWLEDGE · UNDERSTANDING
PREVENTION

THE ALCOHOLISM FOUNDATION OF ALBERTA

The Alcoholism Foundation Of Alberta

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The Alcoholism Foundation of Alberta is a private Foundation incorporated in 1951 under the Societies Act, financed by provincial and municipal grants, corporate and private contributions. The Foundation's three point program of Education, Treatment, and Research, is directed at the eventual Prevention of Alcoholism in Alberta. Patient counselling, medical, educational, and research services are provided through the two centres in Edmonton and Calgary. The Foundation recognizes alcoholism as a treatable illness, a serious public health problem, and therefore a public responsibility.

TREATMENT

Treatment services are available to anyone desiring help with a drinking problem. The treatment program includes individual counselling, medical treatment, and group therapy. A service fee of $10.00 is charged to the patient. No patient is ever denied treatment due to inability to pay. There are no consulting fees.

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Monday through Friday

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Medicine Hat Information and Referral Centre. Hours: 9 a.m. to 5 p.m.
Municipal Hospital — Wednesday
Telephone JAckson 7-2211
Appointments made through Medicine Hat Health Unit,
Telephone JAckson 7-1136

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Grande Prairie Hospital — Second and Fourth Thursday of each month
Telephone 532-2315
Appointments made through Grande Prairie Health Unit,
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PROGRESS

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PROGRESS is published four times a year as part of the Foundation's Educational program. All material in PROGRESS is believed to have been obtained from reliable sources, but no representation is made as to the accuracy thereof. Opinions expressed in the articles themselves are not necessarily those of The Alcoholism Foundation of Alberta, but are those of the authors reported.

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PROGRESS
9929 - 103rd Street
Edmonton, Alberta

Volume III, Number 4 **CONTENTS** Edmonton, March, 1962


HURDLES
IN
CONTINUING
SOBRIETY

A talk given to Foundation patients

MANY alcoholics establish and maintain sobriety for considerable periods of time, but then return to drinking. Frequently this occurs because they have not anticipated nor prepared for some of the hurdles and difficulties they will experience while recovering from alcoholism.

Every person wants rewards and satisfactions as a result of his efforts. The alcoholic expects satisfactions from sobriety, but if these are not sufficient, he may return to drinking. It is hard to say how much satisfaction will be considered 'sufficient'—and alcoholics frequently expect more than is realistic. If, however, the newly recovering alcoholic has in advance a realistic idea of some of the probable 'dissatisfaction-producing' situations he will encounter as his sobriety extends, he will be better able to deal with his feelings and retain his sobriety more successfully.

Individual problems and difficulties which may threaten sobriety will vary considerably, but there are some factors which are common to nearly all middle and advanced-stage alcoholics. Following are a few of them:

1. When an alcoholic decides to stop drinking it is because he is dissatisfied with many of the consequences of his drinking. When he makes this decision, he feels a little better—all people obtain a certain satisfaction in making a decision to face a problem. However, the alcoholic is probably in poor physical and emotional shape, and as he starts a period without alcohol, he begins to feel worse instead of better. These feelings of satisfaction are short-lived and are soon replaced by feelings of dissatisfaction and distress. As his physical condition slowly improves and as he realizes that his whole world hasn't quite collapsed around his ears, his emotional condition also improves. In addition, he is actually maintaining his sobriety and some hope and self-confidence return. By carrying out a long-deferred decision to stop drinking, the alcoholic experiences an increase in feelings of satisfaction.

2. Two to three months of sobriety is often enough to convince the alcoholic that he 'has it made' and no more special effort in the way of treatment or attendance at AA is necessary. He may decide it is quite safe for him to go in and have a 'juice' with the boys. He is letting his guard down and the thought 'One won't do me any harm' is close. This period can be unsettling to the recovering alco-

holic. He hits a plateau—feelings of satifaction from sobriety are no longer increasing, so the feeling that he is progressing may be lost.

Several other factors make this a rather dangerous period:

—He has been sober now long enough to appreciate his situation more clearly—to realize that the road back is long, and may be slow and bumpy in places. He may begin to doubt that he can really regain a satisfactory amount of what he has lost or he will begin to feel frustrated and resentful about how long it may take.

—Others start making demands on him. He has been sober for a while, but there is less approval voiced of this accomplishment and perhaps more disapproval of other things he is, or is not doing.

—Dwelling on past losses may reduce his recently regained feelings of self-confidence and hope.

3. The combination of these factors often causes a marked decrease of satisfaction. Sobriety hardly seems worth it. Restlessness, despondency, irritability, strong temptation to drink, 'I might as well be drunk as the way I am,' 'I'm no good sober either,' are common expressions and feelings during this phase. The alcoholic tends to avoid others during this period, because he feels that they are critical of him and doubt his ability to make a come-back. He may wish to avoid treatment interviews or AA meetings. Often he will rationalize his withdrawal from treatment or missed AA meetings by saying he 'doesn't want to be a nuisance' or he 'doesn't want to bother anyone.' At a time when he most needs support and re-inforcement, he feels too guilty to seek it.

4. A dull 'what's the use' attitude may now develop—he will feel unhappy and depressed about the present and the future. The thought, 'A drink or two would sure help me along,' may be a constant threat. Rationalizations may appear such as, 'A drink or two would help me get a job,' 'I could sell better with one under my belt,' 'A drink would give me a good night's sleep and cut down this jitteriness.'

5. Next comes a period of reorganization, of facing what has to be done and deciding how to do it—a period of getting accustomed again to living with the tensions and frustrations of every day life. Along about now, like a person who gets a 'second wind,' he again starts to experience a few satisfactions from sobriety. From then on there will be a slow, steady gain in the overall satisfactions from sober living, until he reaches an average level and average balance between rewards and dissatisfactions in his day to day living. He must, however, be prepared to handle, cold sober, for the rest of his life, the difficulties, frustrations, disappointments, irritations and hurts that many non-problem social drinkers handle with the help of a drink or two.

SPECIFIC HURDLES

FOLLOWING are brief outlines of some of the specific hurdles the alcoholic will have to face and overcome if he wishes to maintain sobriety.

Unemployment

Often the alcoholic has no job and his work record in the past several years will be more of a detriment than a help in finding one. He may be turned down many times and become discouraged and reluctant to face the risk of further rejections. He should be prepared for this. Finding a steady job won't be easy.

One of the most important things for the advanced alcoholic to do is to re-establish a record of job stability. Therefore he may be well advised to keep his employment sights relatively low; to find a bread and butter job and hold it for 6 to 12 months. He will then have a period of steady employment to refer to when a better job opportunity comes along.

Debts

By the time the alcoholic does make a serious attempt to stop drinking he may have little money and lots of debt. The alcoholic must discharge his debts, but he cannot do this in a few months—it may take several years. After he secures steady employment and can budget his income, he should plan to discharge his debts gradually.

Attitude of Children

The alcoholic's children may have learned during the course of his illness to disregard him. It will take a while for them to unlearn this. During the first year of his sobriety, his children may act toward him in ways that he considers disrespectful or they will seem to show little regard for his opinion. During the last few years, they have learned to turn to their mother as the authority in most things concerning the family. Naturally, as father and husband, the alcoholic resents his lost role. He must, however, be prepared to be patient with his children and give them plenty of time to recover their respect and love for him. As his sobriety extends, this will occur. He should guard against temper outbursts and authoritative demands for proper respect, as these will only impede the change in the children.

Attitude of the Spouse

Many an alcoholic who is doing a good job of maintaining sobriety feels that his wife is unnecessarily anxious about him and is always ready to worry for fear he is going to 'sip.' His irritation about this, if he isn't careful, can build to the point where he begins to feel that he might as well 'give her something to worry about.' An alcoholic should try to remember that his

wife's anxiety is the result of long and painful experience and also that much of it is based on genuine concern for him. It is natural for her to worry when he is late getting home, or when he is under tension of some kind, and he should try his best to accept this without resentment, and reassure her.

As his period of sobriety increases, she will gain increasing confidence. Only his continued sobriety can break her habit of worrying about whether he is going to 'fall off' again.

Frequently after several months of sobriety, marital friction will develop in the home of the recovering alcoholic over 'who is running the house,' or 'who is in control of family affairs.' Often, as the husband's alcoholism progressed, the wife has had to take over control of the household in order to keep the family together. She may have become accustomed to making most of the decisions and may find it difficult to give up this role.

Wives of alcoholics frequently say of their drinking husband 'he's a wonderful husband when he is sober. If he would only quit drinking our marriage would be perfect.' When sobriety does occur, a wife may fail to realize that her husband is trying his best to make up for his behavior during drinking. He is bending over backwards to be pleasant and considerate—he does not argue, or contradict, or demand his own way.

After he has maintained sobriety for a period of time, he doesn't need to be continuously atoning or agreeing with everything in order to prove he is a nice person. In other words, when permanently sober, he reverts to being an ordinary rather than perfect husband. A wife may be accustomed to a husband who is belligerent and demanding when drunk, but she is often not prepared for behavior which is demanding or critical when he is sober. Readjusting to this 'new person' may be difficult for her. It is often helpful, at this stage, for both partners to have professional counselling. This will facilitate the necessary transition from the pre-sobriety disorder of the marriage to a comfortable, enduring relationship.

High Spots

Often alcoholics who have held their sobriety through periods of real distress and hardship will start to drink when they get a 'lucky break' or when things are going well and they are regaining ground rapidly. Every recovering alcoholic should be aware that, when he has overcome many of his problems, there is a likelihood that he will start to drink. He may feel that since he has solved most of his problems and is no longer worrying as much, he should be able to take a drink or two like others and keep it under control. If he does try this, he takes the first step back to all the worries and difficulties he has just overcome.

Dry Drunks

This is an apt AA term and

refers to a condition that many recovering alcoholics experience — even after substantial periods of sobriety.

A 'dry drunk' is a period of several days when the alcoholic feels depressed, apprehensive, unable to sleep—for no apparent reason. As sobriety extends, these periods will occur less frequently and will be less intense. The alcoholic who is not prepared for the occurrence of a 'dry drunk' may get panicky and feel that he is cracking up. The recovering alcoholic, who begins to experience one of these tension periods, should get in touch with his treatment clinic or with his AA friends or with both, and strongly resist the old habit of thinking that 'a couple of drinks would settle me down.'

Delayed Fatigue

During the early period of sobriety feelings of fatigue are only one of a number of distressing feelings that the alcoholic may have. These feelings become less troublesome as sobriety extends and as physical and emotional health improves. Sometimes, however, after six or twelve months of sobriety during which he has achieved better general health than he has enjoyed for years, he will experience a sudden drop in his general energy level and will feel very tired for a period of time.

Why this occurs has not been satisfactorily explained, but it is quite common among recovering alcoholics during the six to eighteen months period of sobriety — and may occur even after that. If it does occur, the alcoholic should not feel he has to try to ignore these feelings. He should get additional rest —and lots of it. Wives and families of alcoholics should be made aware of this phenomenon. If the recovering alcoholic tries to ignore the feeling of acute fatigue and persists in his usual activities despite them, the whole cluster of distressing feelings common to the early period of sobriety may return. Fatigue in the alcoholic when improperly understood and managed, may possibly be the precipitating factor in the so-called 'dry drunks.'

BUILDING A NEW SELF-IMAGE

ALL OF US carry around a mental picture of the kind of person we are. All our various attributes, whether real or imaginary, of a physical, mental or emotional nature, are contained in our individual 'self-image.' A person who has developed alcoholism must obviously have a well-developed concept of himself as a drinking per-

son. This concept is the result of years of drinking and it is reinforced by the fact that he is known to his friends as a drinking person.

When the alcoholic decides to stop drinking, an important part of his self-image is disrupted. It is very difficult for the alcoholic to begin to change his image of himself so that he thinks of himself as a non-drinking person. He may even feel a certain hostility towards the abstainer or think of him as queer or strange. Naturally, then, he would not want to picture himself as a non-drinker. In spite of this, the alcoholic must change his self-image from 'drinker' to 'non-drinker' if sobriety is to be maintained without great discomfort. He must learn to accept this concept of himself as real and he must be able to say, unemotionally, in any company, on any occasion that he does not drink. There must be no loop-holes in this new picture of himself as a non-drinking person.

How Does One Change the Self-Image?

Knowledge and practice are the main tools to bring about a change. The alcoholic must have adequate knowledge of the facts of alcoholism. He needs to recognize that it is a chronic disease and any further intake of alcohol is inadvisable and treacherous to his well-being. On the basis of this knowledge, the alcoholic must begin at once to practise thinking and acting as an abstainer. He must learn to discuss his condition when necessary, without shame or confusion, until he becomes completely at ease with this new aspect of himself. He must learn how to decline a drink gracefully, without offending or embarrassing his host and, even more important, he must learn how to say 'no' to his own inner urgings to drink. He must confront himself with his own rationalizations, whether public or private, and adopt and practise new ways of handling the tensions of every day life.

TESTING

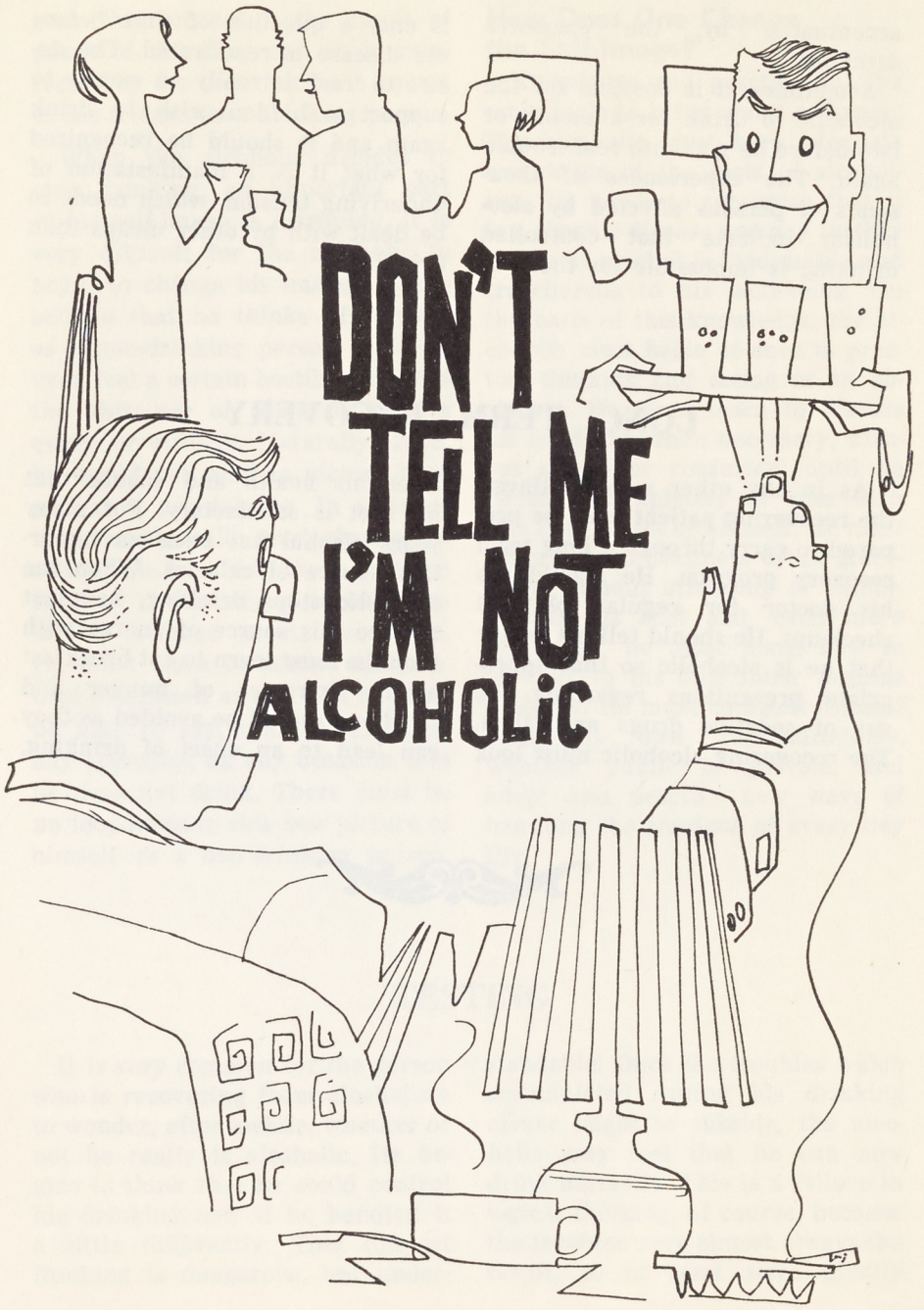
It is very common for the person who is recovering from alcoholism to wonder, after awhile, whether or not he really is alcoholic. He begins to think that he could control his drinking now if he handled it a little differently. This line of thinking is dangerous, but understandable. Once the troubles which accumulated during his drinking career begin to subside, the alcoholic may feel that he can now drink normally. This is a failure in logical thinking, of course, because the troubles were almost always the result, or at least were greatly

accentuated by, the excessive drinking.

Sometimes, it is possible for the alcoholic to drink for a month or two before he gets into real trouble again. The experiences of thousands of persons affected by alcoholism indicate that controlled drinking is impossible for them. It is only a question of time before the disease is reactivated. The desire to 'test' is really an excuse to support a hidden wish to drink again and it should be recognized for what it is, a manifestation of underlying tension, which needs to be dealt with by other means than drinking.

LONG TERM RECOVERY

As in any other serious illness, the recovering patient must be prepared to carry through a long term recovery program. He should see his doctor for regular physical check-ups. He should tell his doctor that he is alcoholic so that appropriate precautions regarding the use of sedative drugs are taken. The recovering alcoholic must look after his health and ensure that his diet is satisfactory. For many years alcohol has been an important source of calories. When the alcoholic stops drinking, he must replace this source of energy with food: he must learn to eat breakfast again. Extremes of hunger and tiredness should be avoided as they can lead to an onset of drinking.


DON'T
TELL ME
I'M NOT
ALCOHOLIC

By John Boit Morse

PLEASE DON'T TELL me I'm not an alcoholic. You endanger my life if you do. If you persuade me to take a drink, 'just a little one,' I could die because of it.

I am writing this article because I am an alcoholic and well-meaning friends keep telling me I'm not. 'An alcoholic? Don't be silly! Not you!' they say. 'Oh, maybe you did drink a little too much, but you were under a lot of pressure then. That's all over now. Come on, boy . . . say when!'

I have known alcoholics, struggling to eliminate alcohol from their lives, who did weaken, who did 'say when.' I have seen the grim trap of addiction close on them again. I have seen them die of it. Many alcoholics do. If allowed to run its course, alcoholism is a fatal disease. It can be arrested, if the victim stops drinking, but it cannot be cured! Long abstinence makes absolutely no difference. An alcoholic who has not touched liquor for 20 years is just as much an alcoholic as he ever was. To tell such a person that he doesn't have an incurable and fatal disease is absolute madness — and all too often it is exactly what the victim wants to hear.

Nobody enjoys being an alcoholic. Most of us who are on a program of recovery—and we represent only six or seven per cent of all alcoholics—have struggled to a painful acceptance of a stark fact: We are *physically different* in our reaction to alcohol. *We cannot drink.* On our constant recognition of this fact depend our happiness, our sanity, our lives. But we are like tightrope walkers; one small push can send us hurtling into the depths below.

Why are well-intentioned people sometimes guilty of giving us this push? In the first place, friends who are fond of us don't want us to be alcoholics because of the stigma that is still attached to the label. Medical science has at last tagged alcoholism for what it is—a disease. But public opinion is slow to follow. So, when a friend tries to tell you that you're not an alcoholic, he thinks he is doing you a kindness.

In the second place, many people still have a fixed and stereotyped conception of what an alcoholic is —a human derelict on Skid Row, or a moneyed ne'er-do-well languishing in some institution. If you don't fit into either category, they find it impossible to believe you have lost your tolerance for alcohol.

In the third place, your admission that you are an alcoholic disturbs some of your friends because it is a threat to their own drinking habits. If this fellow is an alcoholic, they say to themselves uneasily, what about me? There is little logic in such a reaction; only one drinker out of 15 or 16* becomes an alcoholic. But I have had the distinct

*In the U.S. The rate in Canada is approximately one drinker in 30.

impression, on many occasions, that the person loudly assuring me that I couldn't be an alcoholic has really been trying to reassure himself.

And finally, alcoholics often have to face strong opposition from close relatives who feel that any such admission will bring disgrace or disapproval upon the family. Recently a good friend of mine died of alcoholism at the age of 43. Doctors found her physical disabilities indicated she had been an alcoholic for a great many years. Yet six months before she died, her father told me impatiently that she wasn't an alcoholic, and named a dozen women who drank more and behaved far worse. All her friends and relations had assured her that she wasn't an alcoholic. Most of them still think she died of heart failure, a falsehood that the newspapers faithfully recorded.

THE ONLY WAY an alcoholic can begin a program of recovery is through recognition of his disease. This is never easy since addiction invariably carries with it a deadly tendency to justify, to rationalize, to deny anything that might bring about the end of drinking. Believe me, I know. I went through it myself.

A number of years ago, three people very close to me seemed to have drinking problems, so I obtained and read Marty Mann's 'Primer on Alcoholism' with a view to being of help. Several years later, my own drinking behavior was sufficiently abnormal and depressing to make me recall the book. I reread it, and I also read 'Just One More', by James Lamb Free. It was a grim experience. I tried frantically to dodge. I sought every means to prove that I wasn't an alcoholic. But the evidence was too strong.

What evidence? Well, in one of his classic studies, Dr. E. M. Jellinek lists the characteristics displayed by the victim of alcoholism in three successive stages of the disease. I found that many of these descriptions applied to my own behavior. Black-outs, for example. These are episodes involving loss of memory, and should not be confused with 'passing out.' There were many times when I would play bridge quite competently all evening, and have little or no recollection of it the next day. Once I drove 120 miles from San Francisco to my home in Pebble Beach, and woke up the next day with no awareness of having made such a trip.

MANY OTHER symptoms listed by Dr. Jellinek were present in my drinking pattern, although, like many alcoholics, I usually succeeded in keeping them from my friends. Sneaking drinks, evasiveness about drinking habits, excessive remorse the morning after—the signs were all too plain. I was still years from Skid Row, but I was on my way. I didn't look like an alcoholic, and I obviously didn't act

like one—but when I finally described my symptoms to a doctor, he confirmed my fears—I was one!

I remember very well the reaction among some of my closest friends. It was almost violent: derision, denial, anger, endless proof that I could not be an alcoholic. Soothing, wonderful words to a man who craves a drink! Welcome justification for starting all over again!

I know now that these reactions were based on ignorance — false conceptions of what an alcoholic is and how the disease works. Nobody knows all about alcoholism; even to the experts, some aspects of it remain a mystery. Let me try to dispel a few of the major misconceptions.

To begin with, please don't consider the alcoholic a moral weakling. Actually, he may have more will power than you have. But he is ill—the sickest of men.

Next, don't limit your mental picture of an alcoholic to the derelict in the last stages of the disease. There lies the derelict in the gutter, close to insanity or death. Has he just recently become an alcoholic? Was it five years ago when he became a dishwasher? Was it ten years ago when his wife divorced him?

Was it 15 years ago when he lost his bank job? Was it 20 years ago when he first began sneaking his drinks to make sure of getting his share? Was it 25 years ago when he had his first blackouts? Today science knows that he became an alcoholic at least 25 years back—and that he was just as much an alcoholic then as he is now.

TRY TO REMEMBER that alcoholism is an iceberg disease —the symptoms are largely hidden, at first. In fact, during the first five or ten years of their addiction, alcoholics generally take great care to appear as normal social drinkers. It is the heavy drinker or occasional drunk who misbehaves. It is the alcoholic who apparently remains sober. But it is the alcoholic who slips away first from a cocktail party, often on the pretext that he has work to do, but who then goes home or to on out-of-the-way bar and satisfies his grim, compulsive need.

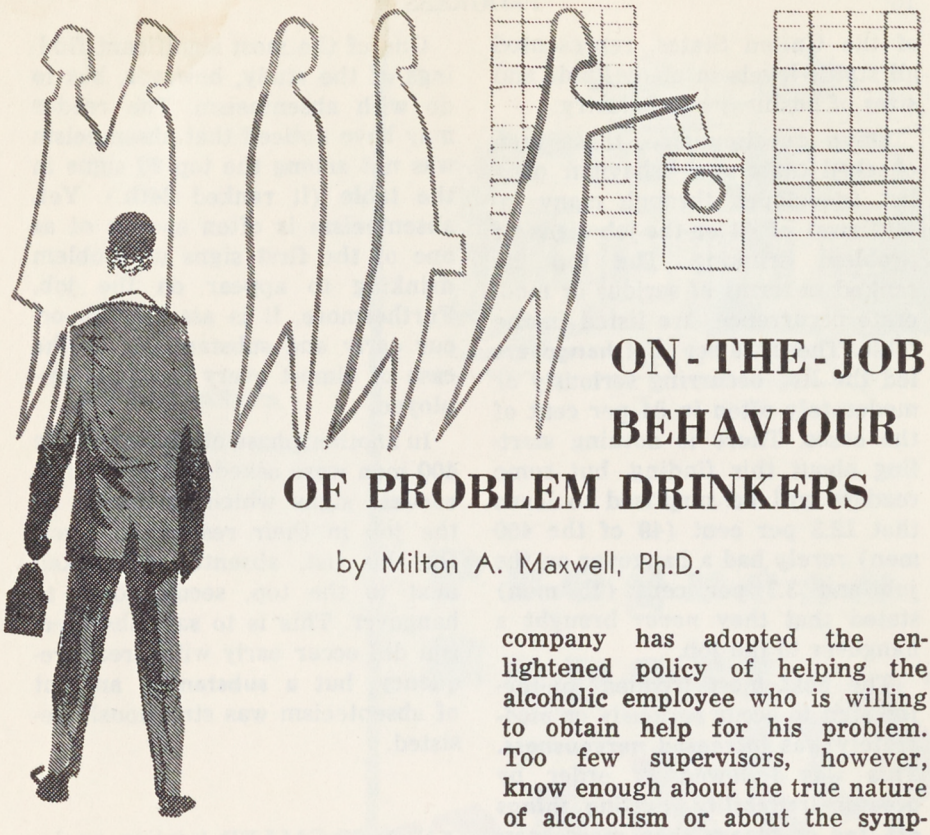
Don't be misled by appearances. My wife, Virginia, who recovered from alcoholism when she was 29, is a youthful and energetic woman. People meeting her for the first time, learning of her disease, invariably protest, 'You can't be an alcoholic; you look as healthy as a child!' She is an alcoholic — and looks as youthful as any victim of the disease who has been blessed with an early recovery.

Alcoholics Anonymous leaves statistics to the medical authorities and the research groups, but it is a generally accepted fact that in the beginning, some 24 years ago, the average age of AA members was 50 or more, because only end-of-the-liners were thought to be alcoholics. Today, younger people are joining in various programs of re-

covery. Most newcomers to AA nowadays range from teen-agers to persons in their 20's, 30's or 40's. They are recognizing the disease early.

THIS BRINGS me to one last recommendation. Sometimes the young recovered alcoholic is told that he must have had a light case since it didn't progress very far, and that surely he must be able to take a little wine or beer. In the first place, there is no such thing as a 'light' case. The alcoholic who crosses the invisible line is—and will remain — an alcoholic all his life. And there is no such thing as a partial alcoholic: either you are one or you're not. In the second place, it doesn't matter whether the fatal drink is wine, beer, 100-proof bourbon — or for that matter a cough syrup with an alcohol base. It is the alcohol that does the damage, in any form.

But don't tell them they're not alcoholics. If you are wrong and they believe you, they may die.



ON-THE-JOB BEHAVIOUR OF PROBLEM DRINKERS

by Milton A. Maxwell, Ph.D.

THE ALCOHOLIC employee not only *can* be a "hidden man" but *usually* is. Research evidence to support this claim was given in the December issue of PROGRESS.

Much of this, it was pointed out, was due to strenuous efforts by the employee himself to hide his problem at work even after his home and social life had begun to deteriorate. But, it was also shown that after signs of problem drinking do begin to appear on the job, supervisors often join in hiding the problem from superiors up the line. There is less of this when the company has adopted the enlightened policy of helping the alcoholic employee who is willing to obtain help for his problem. Too few supervisors, however, know enough about the true nature of alcoholism or about the symptoms of the early and middle phases of this progressive pattern to have a solid basis for recognizing and properly evaluating the early signs of alcoholism when they do show up in the case of a particular employee.

TO IMPROVE our knowledge about the actual on-the-job behaviour of problem drinkers, the writer undertook a study of 400 male alcoholic employees who had 'recovered,' or were under treatment at a clinic.[1] These 400 men, mostly from the highly industrialized Eastern and Midwestern areas

of the United States, represented all status levels in many kinds and sizes of business and industry.

On a questionnaire, these men checked their own behaviour on a list (developed through many interviews) of 44 on-the-job signs of problem drinking. The top 20, ranked in terms of serious or moderate occurrence, are listed in the table. There we see that **hangovers** led the list, occurring seriously or moderately often in 84 per cent of the cases. There is nothing startling about this finding, but some readers will be surprised to learn that 12.3 per cent (49 of the 400 men) *rarely* had a hangover on the job and 3.7 per cent (15 men) stated that they *never* brought a hangover to the job.

The next most frequent on-the-job sign to occur seriously or moderately was **increased nervousness.** This was followed in order by **greater irritability, putting things off, red or bleary eyes, more spasmodic work pace, sensitivity to opinions about own drinking, hand tremors, avoiding boss or associates,** and **neglecting details formerly attended to.** These are the top ten signs, occuring seriously or moderately in two-thirds or more of the cases.

The next ten signs, shown in the table, occurred seriously or moderately in 55 or more per cent of the cases. A careful reading of this list of 20 signs is most revealing.

[1]Early identification of problem drinkers in industry, Quarterly Journal of Studies on Alcohol, 21:655-678, 1960.

One of the most significant findings of the study, however, has to do with absenteeism. The reader may have noticed that absenteeism was not among the top 20 signs in the table (it ranked 24th.). Yet, absenteeism is often spoken of as one of the first signs of problem drinking to appear on the job. Furthermore, it is assumed to occur early and substantially in the case of almost every alcoholic employee.

In another phase of the study, the 400 men were asked to list the **five earliest** signs which appeared on the job in their respective cases. On this list, absenteeism ranked next to the top, second only to hangover. This is to say, absenteeism did occur early with great frequency, but a **substantial** amount of absenteeism was strenuously resisted.

IN A SO-CALLED 'scaling analysis' of the relationship of the signs to each other, the 44 signs were grouped into four categories: 1) **hangover,** 2) **absenteeism** (including all partial forms such as tardiness, leaving post temporarily, leaving early, longer lunches), 3) evidence of **alcohol in the blood at work,** and 4) **physical** or **behavioural** signs of a drinking problem such as increased nervousness, hand tremors, spasmodic work pace, etc.

This analysis revealed that substantial **absenteeism** did not occur until each of the other 3 groups of

Eighth
Annual

Progress Report

SUMMARY

Period:
January 1, 1961
December 31, 1961

THE ALCOHOLISM
FOUNDATION OF ALBERTA

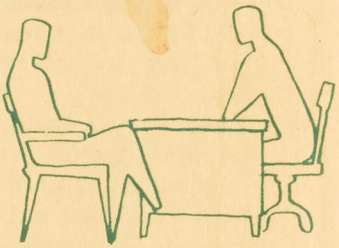
1961 A SUMMARY OF THE

THE ALCOHOLISM FOUN

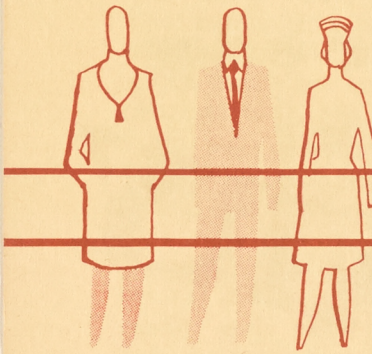
491 NEW PATIENTS

442

49



8,057 INTERVIEWS



TREATMENT

368 GROUP THERAPY SESSIONS

PROGRESS TRENDS
1953 - 61

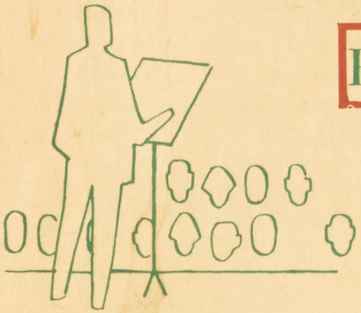
Recovered or Improved
56%

Unimproved
33%

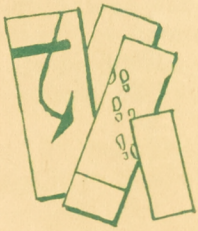
Under Active Treatment
11%

THE YEAR'S ACTIVITIES 1961

FOUNDATION OF ALBERTA



EDUCATION



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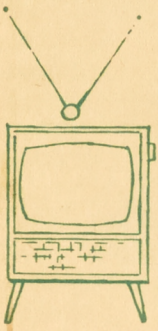

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ON-THE-JOB DRINKING SIGNS RANGED BY PER CENT OF ALCOHOLIC EMPLOYEES INDICATING SERIOUS OR MODERATE OCCURRENCE

Drinking Signs	Degree of Occurrence: Serious or Moderate % *	Rare or Mild %	Never %
1. Hangovers on the job	84.0	12.3	3.7
2. Increased nervousness	82.8	13.9	3.3
3. Greater irritability	75.3	15.4	9.3
4. Putting things off	72.3	15.7	12.0
5. Red or bleary eyes	70.3	20.2	9.5
6. More spasmodic work pace	69.2	17.4	13.4
7. Sensitivity to opinions about own drinking	68.3	18.7	13.0
8. Hand tremors	67.9	21.7	10.4
9. Avoiding boss or associates	67.3	17.5	15.2
10. Neglecting details formerly attended to	65.8	22.0	12.2
11. Indignant when own drinking was mentioned	65.7	19.7	14.6
12. Drinking at lunch time	61.1	16.6	22.3
13. Morning drinking before going to work	60.7	18.1	12.2
14. Flushed face	60.4	23.3	16.3
15. Lower quantity of work	59.6	23.6	16.8
16. Using "breath purifiers"	59.1	20.4	20.5
17. Making mistakes or errors of judgment	58.3	34.0	8.7
18. Lower quality of work	57.8	23.1	19.1
19. Mood change after lunch or other drinking	55.8	19.4	24.8
20. More intolerant of fellow workers	55.7	22.3	22.0

*Total responding to each item ranged from 400 to 379.

signs was showing on the job in substantial fashion.

This analysis also showed that repeated evidence of **alcohol in the blood** did not occur until there were many **physical and behavioural** signs showing on the job plus **hangovers.**

What we seem to have is this. As the drinking problem becomes progressively worse, more and more signs will appear on the job. But morning drinking before going to work, or drinking during the work day, is avoided because it is looked upon as a serious threat to keeping the job. The same is true of absenteeism. But, when the drinking problem becomes bad enough, drinking before going to work, or

at work, is risked in order to avoid the even greater risk of more absenteeism. Thus, substantial absenteeism will seldom occur until even drinking on the job can no longer prevent it.

NOW, how does all this, including the other findings of the study, help the supervisor to know when he has a problem drinker on his hands?

Obviously, substantial absenteeism can occur for reasons other than problem drinking. So can all the observable physical and behavioural signs on the list. These may all be due to some other problem or problems. But, when either repeated absenteeism or evidence of physical or behavioural disturbance is accompanied by *either* repeated hangovers *or* any signs of alcohol in the blood at work (except where lunch-time drinking or other drinking at work is generally permitted), the supervisor has every reason to suspect that he has an alcoholic on his hands.

He will then do well to keep his eyes open for signs of repeated hangovers (headache, thirst, jitters, procrastination, and avoidance of others, etc.); for repeated signs of alcohol in the blood, such as the aroma of alcoholic beverages on the breath, aroma of breath 'purifiers' or 'covers,' avoidance of others, or striking mood changes during the day. And, according to the study, he can look for other easily observable signs, common in the case of alcoholic employees, such as red or bleary eyes, flushed face, hand tremors, increased nervousness, greater irritability, a less even or more spasmodic work pace, putting things off, neglecting details formerly attended to, and any evidence of a deterioration in work performance.

WHEN we keep in mind the point made at the beginning, that the problem is usually in existence and hidden for some time before the first signs show on the job, then it is clear that supervisors need to place a more serious interpretation on the signs when they do begin to show on the job, especially when they show repeatedly in the combinations revealed in this study.

Milton A. Maxwell, Ph.D., who spent a year in Alberta as Consultant and Director of Programming for the Foundation, is Professor of Sociology at Washington State University, Pullman.

Doctors in AA

What can we AA members do to help the millions of our suffering brother and sister alcoholics who have not yet profited from our program of recovery?

That question was put to guest speaker Dr. E. M. Jellinek, non-alcoholic dean of the world's alcoholism scientists and a long-time friend of AA, at the twelfth annual meeting of International Doctors in AA in Toronto, Canada.

Dr. Jellinek had two specific suggestions: 'Remain flexible,' he said 'and develop new sets of language in which to express your unchanging principles— terms which are understandable to other alcoholics. It's a matter of communication.'

Dr. Jellinek also said he foresaw a brilliant future for AA, so long as it continues to adapt itself and develop new techniques to meet the ever-changing present. He pointed out that the concepts and ideology of early-day AA seemed to be most effective with 'last gasp' alcoholics, but as time has passed the AA terminology has evolved to attract both the 'high bottom' and the young alcoholic. If AA's framework of ideas can be put into new terms which awaken therapeutic, healing echoes in those alcoholics who cannot respond to AA as it is now generally presented, they too might be helped, Dr. Jellinek suggested. He said the alcoholic population so far not reached by AA may be as large as 99.5 percent of the *world's* alcoholics. AA seems to be now effective with between one-half and five percent of the alcoholics in any given North American, British or Scandinavian culture.

The annual AA doctors' assembly is a good example of a specialized, highly developed communication technique which reaches alcoholics otherwise not touched by AA. Their meetings reveal a way of 'carrying the message' uniquely effective with doctors who suffer from alcoholism, men who might never have found AA in the ordinary way.

I asked the doctor who started the 'International Doctors in AA' if alcoholic doctors have a harder time with the AA program than some members, and if special doctors' meetings help. He has been sober more than fifteen years, and has attended all the AA doctors' special meetings.

Here's what he said: 'As my drinking got worse and worse, three psychological obstacles held me back from AA: What will my be-

loved profession think of me and will I be barred from practice for being an alcoholic, or for admitting it, or for seeking help from laymen; if I went to AA and it became known, would I have a medical practice and be able to make a living for my family; what would my friends think if I went to AA?'

All three drawbacks were thrown off one bitter day when he felt so desperate he declared aloud, to himself, 'I don't give a damn what anyone thinks; I want to get well!' And so the drinking doc finally found AA and sobered up. Now he has answers for each of those doubts which once kept him from AA.

A few years ago his county medical society honored this man with a special 'award of merit' because of his work with alcoholics. His private practice so flourished that it got out of hand and he finally had to give it up and retire to a less strenuous public health post in another state. He lost only one friendship because of his sobriety, and that was with a man who seems to have a drinking problem.

After several happy years of sobriety, this doctor began to wish he could talk over AA with fellows who were not only AA members, but also members of his profession. 'A doctor is trained to use self-assurance as a useful treatment device,' he said. 'It comforts patients, and an MD learns to admit his doubts only to another MD; not even his wife. I wasn't discontented with laymen's AA, but I thought it would be even nicer to have a fellow alky medic around.'

Another idea grew at the same time. 'One sober doctor in AA could have little effect on the medical profession,' he said, 'but an organized group of respected physicians, all of them good, sober AA members, might be a real help to my profession in its attempt to understand alcoholism and its treatment.'

He discussed his idea with many sympathetic medical men, as well as the AA General Service people. Then with their advice and encouragement the July, 1949, issue of Grapevine carried a short note, headed, CALLING AA DOCTORS! It announced the plan, purpose and place of the first 'International Doctors in AA' assembly.

Twenty-five medics showed up for that session, and there have never been fewer at any of the succeeding meetings. More than 180 MD members of AA have attended the meetings over the years. One, a Briton, came over from India. Many others from many countries have corresponded; forty-three doctors were present at the 1961 meeting. Doctors came to Toronto from two Canadian provinces and seventeen states and most brought their wives and children. Five of them were psychiatrists, several of whom specialized in treating alcoholics. Almost every other known branch of medical science was represented.

Many of those present are eminent in medical circles, some are even internationally distinguished.

All are respected, licensed practitioners in good standing, and all belong to their appropriate professional societies. Many of them serve on committees or commissions dealing with alcoholism. Obviously, this comparatively small group of AA members wields a far greater influence on the alcoholic problem than some other AA groups can.

ONE OF THE most vital services they have performed is twelfth-stepping other doctors who need help but hesitate to approach AA. As one doctor told me, 'I knew I was having booze trouble, and I secretly suspected only AA could help me, but I simply couldn't bring myself to trust laymen for treatment.' He was one of several doctors present who said that in their case a narrowly literal adherence to the words of AA's Tradition of 'attraction rather than promotion' would have condemned them to death. They were saved when other AA doctors refused to wait for them to become 'attracted' to AA. The sober doctors simply went to their drinking colleagues, broke their personal anonymity privately, and laid the facts about alcoholism and AA on the table. Coming from another doctor, this unsolicited sharing of knowledge and experience has worked for many drinking doctors. Perhaps this Twelfth Step technique is an example of a different kind of carrying the message, or communication, which works with some otherwise unreachable alcoholics.

Virtually all of the AA doctors at the Toronto meeting are active in local AA groups, and many reported serving on local and General Service committees. They seemed to have an unusual respect for AA's Traditions — especially those regarding anonymity and cooperation with other agencies.

The experience reported by a chest disease specialist, sober since 1948, is typical. When he saw the 1949 Grapevine notice about doctors in AA, he longed to go and was relieved to learn he wasn't the only 'peculiar' doctor. He got to the second international doctors' session, and 'Life hasn't been the same since,' he said. 'As AA gave me the courage to hold up my head as an alcoholic, these meetings gave me the courage to hold up my head as a doctor. When I met all these fine doctors in AA, it was the greatest thing that ever happened to me professionally. Association with them has enabled me to assume my real responsibilities within the medical profession.'

He stopped hiding from other AA members the fact that he is a doctor. He has made his own case history known to the secretary of the county medical society. 'Look at all the good just one AA doctor can do in his community,' he pointed out. He said he not only twelfth-steps his patients in his practice, freely discarding his anonymity if he thinks it will do some good, but is called in to help other doctors in trouble. He speaks frequently about alcoholism and AA—both as a doc-

tor and as an AA member—to all kinds of groups, both lay and professional.

'At the annual meeting of International Doctors in AA we get association with men of our own profession in an AA spirit,' he said. 'It is an addition to our AA lives, not a substitute for anything else.'

That pretty well sums up how this grateful non-medical AA guest felt. It delighted my heart to hear in the over-coffee bull sessions far more talk about spiritual values in our program than there was about drug therapy for alcoholics. And furthermore, I came away convinced I had been present at a meeting pointing to some of AA's future growth along exactly the lines Dr. Jellinek had indicated — new channels of communication.

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PASTORAL

'Make My Husband Stop Drinking'

by C. Robert Dickey

Clergymen are often approached by wives of alcoholics with the anguished plea, 'Make my husband stop drinking.' The wife wants the minister to go out right away and talk to the husband, who is drinking his job away, keeping herself and the children in a state of constant turmoil and terror. She has 'tried everything' and now she wants the priest or minister to take over. Should he do so? As a general rule, the answer is 'No.'

If this is surprising to you, consider the situation. In the great majority of cases the couple has been married for a good many years. In the past, and even at this point, the wife has more influence and control over her husband than anyone else, even a priest or minister, whom the alcoholic probably sees as an authority or judgmental figure. If the clergyman goes to see the alcoholic, he will likely reduce the possibility of helping him, and most probably will arouse negativism, resistance, and resentment. The minister will be considered an impertinent intruder into his private affairs, an unwelcome ally of his (he feels) misguided wife. The wife herself has said that she has 'tried everything.' Of course she has; wives of hundreds of thousands of alcoholics have used the same tactics: they have begged, pleaded, wept, nagged, threatened, and punished. They have enlisted the support of the children and they say to Daddy, 'If you loved us you wouldn't behave this way.' They have, in fact, tried everything that has been tried by countless wives for countless years without success. How can the clergyman hope to succeed where wife, children, probably relatives and friends have failed utterly?

How then can the clergyman help? It is likely that he has, in the past, tried to 'reason' with problem drinkers, to bring them to a realization of the enormity of their offences against their families and against God's laws.

If he views alcoholism as an issue of morality and responsibility, the clergyman will fail to help the alcoholic, just as the wife, with the same viewpoint, also fails. But now clergymen, in steadily increasing numbers, are consulting the professional alcoholism programs and members of Alcoholics Anonymous, eager to find out why their old methods don't work, and the 'new approach' does. Clergymen are

learning about alcoholism through seminars conducted by alcoholism programs and many theological colleges now include alcoholism instruction as part of their regular curricula. For effective counselling, this is the First Commandment: 'Learn about alcoholism.'

The clergyman's own attitude toward drinking and alcoholism will largely determine his effectiveness in dealing with alcoholics and their families. In the minds of many, drunkenness and alcoholism are one and the same thing. The conception of alcoholism as an illness and the alcoholic as a sick person who needs help, who can be helped, and who is worth helping, is accepted by many intellectually, but not emotionally. It is resolutely resisted by others, and oddly enough, we find strangely assorted bedfellows in this camp: both the 'liquor interests' and the Temperance-Prohibition advocates. There are those who consider themselves knowledgeable about alcoholism, but whose writings indicate mental conflict and confusion over the ethical-moral aspects of the subject. Here are two examples.

A year or so ago a clergyman with a considerable reputation as a Pastoral Counsellor, who professes great understanding of and compassion for alcoholics, said in a nationally-published article:* 'Let's stop coddling our alcoholics. They got themselves into the jam they're in — they can also get themselves out of it.' He goes on to say:

'The scientific, non-judgmental approach to the alcoholic amounts

*MacLachan, Rev. A. J. Let's stop coddling our alcoholics. Maclean's Magazine, July 30, 1960.

Mr. Dickey's article should help to clear away a great deal of the misunderstanding which does exist still—about this whole field of alcoholism —in the minds of so many of us. Ministers and Pastoral Counsellors, with the help of such articles as this, are awakening to the fact that alcoholism, though apparently due to a lack of moral responsibility in its beginnings, rapidly becomes a progressive and uncontrollable sickness. Sickness, of any kind, can only be treated by those who know both how to identify the disease, and the steps needed for its treatment. Willingness, among clergy today, to accept training and guidance in Alcoholism Counselling from Alcoholism Centres and Clinics across the continent is steadily growing. The fight against alcoholism will be fought more successfully as clergy apply prayerfully the simple techniques outlined here by Mr. Dickey, and learn to cooperate fully in using the trained counsellors available at such centres as The Alcoholism Foundation of Alberta.

REV. ROGER J. MAGGS, B.Sc., L.Th.

The Reverend Roger J. Maggs is rector of St. Philip's Anglican Church, Edmonton, and Chairman of the Diocesan Council for Social Service. He is an editor of THE CHURCHMAN, publication of the Anglican Church.

to coddling. Our attitude toward the alcoholic has become too soft, too maudlin, too sentimental. If we sincerely want to help the alcoholic, we've got to be a lot tougher on him. To pigeonhole him as the casual victim of a disease is a superficial and dangerous diagnosis — a diagnosis that may prevent him from coming to grips with the moral problems that lie at the root of his difficulties.'

This minister appears to advocate the treatment that for centuries **has** been the one accorded alcoholics: the tough treatment, which at various times and in various places has included the pillory, jail, transportation, flogging, stoning, and even death. The old methods consistently failed to do anything but punish; the new methods recognize and treat a pathological condition that is not only a moral and spiritual sickness, but also a physiological, psychological, and social disease. Hundreds of thousands of recovered alcoholics, whose recovery began when they learned that they had a treatable illness, are living testimony to the efficacy of the 'new approach.'

More recently, another clergyman, who is widely known for his work among skid roaders and the frequenters of pubs, wrote in a national church weekly* the following confused and contradictory remarks: 'To describe the excessive drinker as a sick man, and alcoholism as a sickness, is dangerously wrong. Is he sick because he is an alcoholic, or is he an alcoholic because he is sick? The fact is, he is an inadequate personality and he has a sickness only Christ can cure.' And again in the same article: 'The use of alcohol as a social custom raises many issues, and the problem of alcoholism, a disease, raises many quite different issues.'

These two writers quoted above would appear not to have made any serious attempt to 'learn about alcoholism.'

So when the wife of an alcoholic comes to the priest or the minister and pleads for help with her alcoholic husband, the pastoral counsellor must know something about alcoholism and alcoholics, or he is defeated before he starts. There is no lack of authoritative information to guide him—the results of twenty-five years of study by specialists in many disciplines, and by recovered alcoholics themselves.

The wife of the alcoholic can be helped, through knowledge and understanding; and such enlightened counselling can open the door to help for the alcoholic husband. But let the counsellor not expect to accomplish everything in one or two, or even several interviews.

Is this so surprising? Many studies confirm the fact that wives of alcoholics often demonstrate serious emotional disturbances. Even the most well-adjusted wife, after years of frustration, fear, insecurity, and conflict, will suffer some emotional damage. Frequently she will be unaware of her need of

*Packman, Rev. Arthur. United Church Observer, Jan., 1962.

counselling. Her attitude almost certainly will be, 'Who, me? Don't be silly. It's my husband who needs help. There's nothing wrong with me.' The fact is that she does need help.

Naturally the clerical counsellor does not put it to the wife in this blunt fashion. Several interviews may be necessary before the wife herself begins to suspect that perhaps she is also in need of counselling.

If we agree that the wife's attitudes must undergo a change, we must remember a fundamental truth: attitudes cannot be changed unless ways are found, and used, to reduce defensiveness; perhaps 'ego-defensiveness' would be more descriptive. Therapists of the most diverse points of view agree that attitudes toward other people must be changed if the subject is to be helped—attitudes of hostility, or inferiority, or guilt,—and attitudes are changed as defensiveness is lessened.

Before listing the steps by which the parishioner may be motivated to accept professional psychotherapy (individual and group) at The Alcoholism Foundation, or group therapy with Al-Anon (the fellowship of non-alcoholic family members of alcoholics), or preferably both, let us quote the definition of Pastoral Counselling which appeared in the April 1951 issue of 'Pastoral Psychology': '. . . adept listening, whose aim is to discover the internal tensions and external pressures with which the parishioner is struggling; to evaluate his capacity for dealing with these tensions and pressures. Then, without removing his personal responsibility, to help him marshal his capacities and resources (personal, social, and religious), so as to relieve these pressures to a point where he, with an understanding of his situation, is able to deal with them himself.'

If it is by now stipulated that the clergyman has learned as much as he can about alcoholism the illness, and has achieved a thoroughly objective attitude himself, the following suggestions should lead to a more favorable prognosis for both wife and husband.

1. Let her ventilate. Let her unload, talk about her problems and difficulties, with occasional questions to help her with difficult areas or to clarify points. Avoid expressions of approval, disapproval, or sympathy: she has had plenty of these, and they have not helped.

2. Identify the problem. In your study of alcoholism you will have learned a good deal about the phases in the development of the illness, and you will recognize the symptoms described by the wife. You will be able to identify the phase through which he is going at present. Careful, anxiety-reducing questions will bring out all pertinent information concerning the illness.

3. Help her to learn about alcoholism. She will have strong reservations concerning the illness con-

ception, tending to regard it as a willed perverseness. As she begins to understand the basic nature of alcoholism, and to appreciate her husband's perplexing behavior as common symptoms of alcoholism rather than as signs of lack of love and consideration for her and the children, her feelings of confusion and hopelessness are reduced, and she becomes more capable of viewing her situation with some degree of calm objectivity.

4. Focus first on the practical situation. Her concern at present lies here: his behavior, his job, their money, the children. This is a 'safe' area, that is, it is less threatening to her than the area of personal feelings and emotional reaction. You are also giving her time and opportunity to gain a feeling of confidence in your attitude and in your ability to understand the kinds of difficulties and complications she has had to live with.

5. Move the focus to the effects of alcoholism on personal and interpersonal relationships. Keeping it impersonal, avoiding emotional involvement, encourage her growing insight into her own problems. In teaching her about alcoholism, you will have communicated to her some of your knowledge of the effects of alcoholism not only on the problem drinker, but also on those around him.

6. Be aware of the alcoholic's attitude toward his wife. He is at this point likely to be resentful of everything she says or does. He will be hostile to anyone who, he thinks, is 'on her side.' He will make unreasonable demands, be critical and arrogant at one moment, pitiably dependent the next. He doesn't know why he drinks as he does; he is as baffled as she is. His wife is handy, however, and he will project the responsibility on her. When she doesn't respond to his poorly-timed advances, he suspects her of infidelity.

7. Be aware of the wife's attitude to her husband. Much of this has been discussed earlier. She will be deeply hurt, perhaps doubtful of her own worth; she may be afraid that she has failed as a wife, but doesn't know where or how. She has become bitter and withdrawn; he has lied so often and broken so many promises that she cannot believe anything he says. She may believe he is insane. She distrusts his friends and associates.

8. Let her make her own decisions. She may indicate that she is considering separation or divorce. Why then has she come to a clergyman, not a lawyer? Advising her early in the counselling relationship to separate, or not to separate, will almost inevitably reduce the minister's effectiveness. The fact that she came to a clergyman shows that she has an underlying hope for preservation and improvement of the marriage. This hope is worthy of encouragement, but by indirection in the early interviews. It will probably become clear that she has frequently threatened to leave, and

may have left home several times, returning each time in response to his promises to do better. These episodes were part of her 'having tried everything.' She will have to learn to set firm limits and firm alternatives. This learning will take time, and will be discussed a little later.

9. Anticipate objections and resistance. In your studies of the alcoholisms and their attendant problems, you will know in advance just where and what objections to expect, and all the points of resistance that you will encounter. This ability to anticipate her reactions is a powerful and effective tool.

10. Expect, work, and pray for improvement—but be conditioned for failure. Contradictory? Not at all. One of the most eminent of the world's alcoholism specialists, Dr. H. M. Tiebout, is a psychiatrist who experienced almost nothing but uniform failure in treating alcoholics through psychiatry and psychoanalysis. He had become convinced that nothing could help them, until he found that several former patients, whom he had given up as hopeless, had made good recoveries through the fellowship of Alcoholics Anonymous. This aroused his curiosity, and ever since then(the early days of AA and the Yale Centre of Alcohol Studies about 1936-37), he has been in the forefront of those scientists who are devoting their lives to the study of the most complex and baffling of all illnesses, alcoholism.

Many of the most satisfying recoveries have been made against a background of repeated failures. There are, of course, rapid and even spectacular successes, but most are slow and tedious, requiring infinite patience, understanding, and compassion.

But, any improvement is encouraging. Often enough to be thrilling and inspiring, the wife's understanding of alcoholism improves and she begins to 'feel' that her husband has a serious illness, rather than just to 'say' it. She becomes more objective and less panicked, and she is better able to interpret the father's condition to the children. Her ability to talk about, examine, and come to grips with her own problems increases, and her feelings of uncertainty and guilt decrease. She has a growing awareness of what she will and will not accept as her responsibilities. She can better establish and maintain definite limits. She learns how to live more comfortably and efficiently with the problem in the home.

Over a period of time, probably weeks, perhaps months, changes are bound to occur in the home environment of the alcoholic. He is not any more subjected to barrages of nagging, tears, and scolding. His comings and goings are accepted dispassionately. He no longer has the feeling of being hounded and harried and harassed. He becomes more and more perplexed over this new atmosphere in the home, and he must adjust to these changes.

Frequently his adjustment is to present himself for treatment.

The wife's need of counselling is not over by any means. She may now give the appearance of resisting his recovery, perhaps because she is reluctant to relinquish her hard-earned 'head of the family' status, whereas the husband feels that he is earning the right to resume this position. She may have become dependent on the generous outpourings of approval and sympathy to which she has for so long been accustomed. She too will have to adjust.

Actually, most alcoholics do seek someone's help much earlier than is generally recognized, and it is extremely likely that many would stop much earlier, if they knew how to stop, were not so fearful, and didn't feel that they had to do it alone.

The wife's plea for help, then, may in fact be a plea from the alcoholic, but once removed, and the vital importance of this contact lies in knowing something of the background, not only of alcoholism and the alcoholic, but also of the forces at work in the home. The need for this knowledge cannot be overemphasized.

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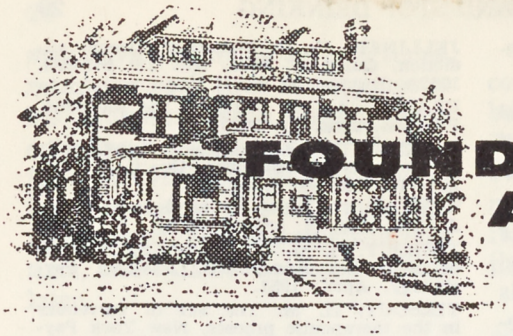

FOUNDATION ACTIVITIES

Mr. R. W. Jones, Director of Research, is taking a year's leave of absence from March 15. He has been appointed Assistant Director at the Center of Alcohol Studies, Rutgers the State University, New Brunswick, New Jersey.

Robert Sommer, Ph.D. is joining the staff of the Foundation as Research Associate from April 15th to September 15th, 1962. Dr. Sommer is Associate Professor of Psychology and Director of the University Testing Service at the University of Alberta.

Mr. J. George Strachan, Executive Director, will deliver a paper dealing with the ways and means of developing an alcoholism program at the International Anti-Alcohol Union Conference to be held in Warsaw from June 11th to 22nd, 1962. He has been granted a bursary to attend the Conference by the Christopher D. Smithers Foundation.

Consultation Clinic at Westlock

In conjunction with the local Community Committee on Alcoholism, a Consultation clinic has been opened in Westlock. The clinic will be held each Friday afternoon at the Whissel Clinic. Patients may make appointments by telephoning the clinic directly. (Telephone 23)

TREATMENT ACTIVITIES

During 1961 the Foundation's clinics in Edmonton, Calgary, Lethbridge, Medicine Hat, and Grande Prairie saw 491 new patients. 276 patients stayed in treatment long enough to warrant 'case' status. This represents an increase over 1960 during which 462 new patients were seen and 241 achieved case status. The number of counselling interviews and group sessions increased; Interviews: 1960—6,837, 1961—8,057; Group Sessions: 1960—315, 1961—328.

Two new counselling staff were added to the Edmonton Clinic: A. M Bolle, Ph.D. and Miss Audrey Allison, B.S.W.

EDUCATION ACTIVITIES

January - March, 1962

Professional and public education activities of the Foundation received considerable impetus during the first quarter, with several new avenues opened, including the following:

Theological students at St. Stephen's College are now among those professional people receiving courses of instruction, six sessions having been held at the United Church College in January. As at St. Joseph's Roman Catholic Seminary, emphasis has been placed on early recognition of alcoholism, pastoral counselling of the alcoholic, and help for the families of problem drinkers.

The dual illness tuberculosis and alcoholism, has long baffled staffs of TB hospitals. A pioneering program has been commenced at Aberhart Memorial Sanitorium, Edmonton, for indoctrination of all Sanitorium staff, in several eight-week series of weekly sessions. The medical staff, all nurses, nursing aides, ward aides, orderlies, dietitians, physiotherapists, teachers, and rehabilitation officers participated.

A Youth Advisory Committee has been formed in Edmonton with the co-operation of the Council of Community Services and the Edmonton Teen Council. Regular meetings are held, and much assistance has already been received from the young people in the preparation of a pamphlet especially for teen-agers. Plans are under way for a 'speakers' bureau' of Committee members, for talks to young people's groups in churches, the 'Y' and the like.

Pursuing the Foundation's interest in 'communicating' with young people, a unique form of seminar was conducted at Jasper Place High School in February, on a Saturday morning, with sixty-five students present on a purely voluntary basis. Several short talks vere given, two specially-prepared films were shown, and a one-hour discussion period involved nine Foundation staff members, each having a small, intimate group of students for easier, freer exchange of thoughts and questions. This approach was considered to be so successful that further plans are being laid for similar occasions

Another innovation was a two-day Seminar for teachers and guidance counsellors of the Jasper Place School Division, at which five staff members lectured and led group discussion of the problems associated with the presentation of alcohol and alcoholism education in the schools.

The Foundation's Orientation Services for nurses in training now has been extended to include all Alberta schools of nursing, with the recent addition of Archer Memorial Hospital in Lamont.

In March the Foundation Information Officers held the first of a series of regular conferences for discussion of present educational

methods and their effectiveness, and for planning additional avenues for placing scientific knowledge before the public and the professions.

Recent additions to the Education Services Department in Edmonton and Calgary were Mr. John Motyl and Mr. Gordon Wemp whose years of experience in journalism and public relations have enabled the Foundation to undertake increased educational activities.

RESEARCH ACTIVITIES

October - December, 1961

The following sub-studies were completed and issued during the quarter:

Geographic Distribution of Outlets for on Premises Consumption of Beverage Alcohol; An index for Program Priority Based on Cirrhosis Deaths, Age 25 and Over, and Population, Age 25 and Over; Offences Involving Confiscation of Liquor.

Progress of some importance was made in the following projects:

Personality Changes Resulting from Therapy; Description of Drinking Problems Among Hutterites in Alberta; Follow-up Study of Foundation Patients; Analysis of Enquiries Opened and Raised to Applicant Status 1956—1960.

OTHER FOUNDATION SERVICES

- **ADVISORY SERVICES:**

  Professional advice and assistance on the problems of alcoholism.

- **AUDIO-VISUAL AIDS:**

  Films, tapes, records, and displays are available on loan.

- **CONFERENCES and SEMINARS:**

  To create a better understanding of the problems of alcoholism and methods of dealing with those problems.

- **INDUSTRIAL WORKSHOPS:**

  For the education of management, supervisory staffs, and general employees in Alberta industry.

- **ORIENTATION PROGRAMS:**

  For nurses, doctors, internes, penal officials, personnel managers, social workers, clergymen, teachers, and other groups.

- **PUBLICATIONS:**

  Progress, Digest on Alcohol Studies, and original brochures and pamphlets.

- **REFERENCE LIBRARY:**

  Books, pamphlets, and publications by authorities in the field of alcoholism.

- **SPEAKERS' BUREAU:**

  For professional, industrial, church, social, school, civic, and other groups requesting information.

The illustrations in Progress are by Harry Heine

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